

DIVISION OF INVESTIGATIVE AND FORENSIC SERVICES

ANTI-FRAUD UNIT BEST PRACTICES

2022



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A special thanks to some of the greatest minds in the insurance industry for helping put together these Best Practices for anti-fraud units in Florida.

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DEFINITIONS

As used in this document, the following definitions shall apply:

- **Department means the Department of Financial Services (DFS).** The term does not mean the Financial Services Commission or any office of the Financial Services Commission.
- **Anti-fraud investigative unit** means the designated anti-fraud unit or division, or authorized contractor.
- **Designated anti-fraud unit or division** includes a distinct unit or division or a unit or division made up of individuals whose principal responsibilities are the investigation and disposition of claims who are also assigned the investigation of fraud.
- **Division** means Division of Investigative and Forensic Services - (DIFS)
- **Fraud Division** means the Bureau of Insurance Fraud
- **Immunity** means freedom from a legal duty, prosecution, or penalty, granted by government authority or statute. Factors considered when granting Immunity include the seriousness of the offense, reliability, and involvement in criminal activity.
- **Insurance** is a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies.
- **Insurance policy** or **insurance contract** means a written contract of, or a written agreement for or effecting, insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements, and papers which are a part thereof.
- **Insurer** means every Insurer admitted doing business in this state except the following:
 - » Reinsurers.
 - » Title insurers.
 - » Fraternal fire insurers.
 - » Fraternal benefit societies.
 - » Firemen, policemen, or peace officers' benefit and relief associations.
 - » Grant and annuity societies.
 - » Home protection.

- **Designated Anti-fraud personnel** includes insurer personnel who the Insurer has not identified as being directly assigned to its SIU but whose duties may include the processing, investigating, or litigation pertaining to payment or denial of a claim or application for adjudication of claim or application for insurance. These personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties.
- **Person** means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, business trust, or any entity involved in the business of insurance.
- **Red flag** or **red flag event** means facts, circumstances, or events which, singly or in combination, support(s) an inference that insurance fraud may have been committed, and includes patterns or trends that may indicate fraud, facts or circumstances present on a claim, and behavior or history of the person(s) submitting a claim or application.
- **Special Investigative Unit (SIU)** means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be comprised of insurer employees or by contracting with other entities for the purpose of complying with applicable sections of the Insurance Frauds Prevention Act (IFPA) for the direct responsibility of performing the functions and activities as set forth in these regulations.
- **State.** When used in context signifying a jurisdiction other than the State of Florida, "state" means any state, district, territory, or commonwealth of the United States.
- **Suspected insurance fraud** includes any misrepresentation of fact or omission of fact pertaining to a transaction of insurance, including claims, premium, and application fraud.

THE DIVISION OF INVESTIGATIVE AND FORENSIC SERVICES

The Division of Investigative and Forensic Services (DIFS) encompasses all law enforcement and forensic components residing within the Department of Financial Services. With this broad responsibility, the Division investigates a wide range of fraudulent and criminal acts including:

- Insurance Fraud Investigations
- Workers' Compensation Fraud Investigations
- Fire, Arson, and Explosives Investigations
- Theft/Misuse of State Funds
- Fire and Explosives Sample Analysis

Insurance fraud is one of America's costliest crimes. Conservatively, fraud losses across all insurance lines amount to at least \$308.6 billion annually. More specifically, property-casualty fraud equals about \$45 billion each year.¹ At the same time, fraud schemes are getting more complex; often crossing into other related industries, such as banking and finance. Eighty-four percent of insurance organizations claim that the fraud cases they investigate involve high profile fraud schemes such as identity theft (49 percent), and/or computer, cyber hacking, and claims (34 percent) (*LexisNexis, June 2016*). In most instances, (76 percent) these cases have a moderate to high financial impact on insurance organizations.²

It is widely understood that insurance fraud depletes an insurer's resources and the losses incurred from fraud can impact consumers in the form of higher insurance premiums. NAIC statistics estimate that insurance fraud cost is approximately \$100 billion annually, and it affects every type of coverage, i.e., health, auto, commercial, or property insurance. To put this in perspective, fraud costs every Floridian \$100 a year for every \$1,000 of their homeowner's or auto insurance premium, with 10 % of all property-casualty premiums collected to pay for the costs to prevent, detect, investigate, and prosecute fraud (Insurance Information Institute, September 2017).

The Division of Investigative & Forensic Services (DIFS) believes insurance companies must treat investigating and reporting suspected fraud as a top priority. Any company that fails to dedicate the needed resources towards the fight against insurance fraud can impact its financial stability and affect rates charged to its customers. No one type of person commits insurance fraud. Insurance fraud is committed by friends, neighbors, doctors, lawyers, and medical providers. Insurance fraud affects us all in Florida. That's why the topic is constantly discussed in the hallways and committee rooms of most statehouses and governing bodies in the United States.

¹Coalition Against Insurance Fraud, <https://insurancefraud.org/fraud-stats/#stats>

²Coalition Against Insurance Fraud, <https://insurancefraud.org/fraud-stats/>

In 2017, the Florida Legislature mandated the Division of Investigative and Forensic Services, hereafter referred to as DIFS, to create a best practice report for anti-fraud units and update it biennially. The report is to detail best practices for detecting, investigating, preventing, and reporting of insurance fraud and other fraudulent insurance acts for anti-fraud units doing business in Florida.

The report was compiled through extensive research as well as the collaborative input of industry professionals, state regulators, and compliance partners. It is expected that insurers maintain a flexible approach to adapt to the rapidly evolving issues of insurance fraud.

In a 2003 study conducted by the Coalition Against Insurance Fraud on Special Investigation Units, the study found no consistency in how small, medium, or large SIU units measure performance. According to the Office of Insurance Regulation's (OIR) 2019 annual report, over eleven hundred domestic insurers have Certificates of Authority to do business in Florida. The companies all operate differently on methodology, business practice, and trade secrets.

This report put together by the Division of Investigative and Forensic Services is intended to provide anti-fraud units with a guide and basic best practices operating an insurance anti-fraud unit in Florida.

Fraud Defined, Civil Immunity & Designated Employees

(a) A person commits a "fraudulent insurance act" if the person:

1. Knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing corporation, purported Insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a claim for payment or other benefits pursuant to any insurance policy, which the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material thereto

Civil Immunity - 626.989(4)(c)

In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports, without malice, or furnishing other information, without malice, required by this section or required by the Department or Division under the authority granted in this section, and no civil cause of action of any nature shall arise against such person:

1. For any information relating to suspected fraudulent insurance acts or persons suspected of engaging in such acts furnished to or received from law enforcement officials, their agents, or employees.
2. For any information relating to suspected fraudulent insurance acts or persons suspected of engaging in such acts furnished to or received from other persons subject to the provisions of this chapter.
3. For any such information furnished in reports to the department, the Division, the National Insurance Crime Bureau, the National Association of Insurance Commissioners, or any local, state, or federal enforcement officials or their agents or employees; or
4. For other actions taken in cooperation with any of the agencies or individuals specified in this paragraph in the lawful investigation of suspected fraudulent insurance acts.

Designated Employees 626.989(4)(d)

In addition to the Immunity granted in paragraph (c), persons identified as designated employees whose responsibilities include the investigation and disposition of claims relating to suspected fraudulent insurance acts may share information relating to persons suspected of committing fraudulent insurance acts with other designated employees employed by the same or other insurers whose responsibilities include the investigation and disposition of claims relating to fraudulent insurance acts, provided the department has been given written notice of the names and job titles of such designated employees before such designated employees sharing information. Unless the designated employees of the insurer act in bad faith or in reckless disregard for the rights of any insured, neither the Insurer nor its designated employees are civilly liable for libel, slander, or any other relevant tort, and a civil action does not arise against the Insurer or its designated employees:

1. For any information related to suspected fraudulent insurance acts provided to an insurer.
2. For any information relating to suspected fraudulent insurance acts provided to the National Insurance Crime Bureau or the National Association of Insurance Commissioners.

Provided, however, that the qualified immunity against civil liability is conferred on any insurer or its designated employees shall be forfeited concerning the exchange or publication of any defamatory information with third persons not expressly authorized by this paragraph to share in such information.

Establishing an Anti-fraud Unit within Insurers

Adherence to Florida Statutes – the development and implementation of anti-fraud programs and investigations conducted should be handled in accordance with governing laws and administrative rules. Section 626.9891, Florida State Statutes mandates that every insurer admitted to doing business in the State of Florida is statutorily bound to establish and maintain an anti-fraud unit, commonly known as SIU, to investigate and report possible fraudulent insurance fraud acts by insured or persons making claims for services or repairs against policies held by the insured; or contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

Legislative actions set the required minimum standards expected of insurers in developing an SIU to investigate insurance fraud.

Anti-fraud programs are expected to vary from insurer to insurer. However, creation of the structure, processes, and procedures is usually based on assessments of the unmitigated risk of fraud within the insurance products and services offered to consumers, with attention to:

- Market conditions, including the migration of ring and organized activity.
- Data Trends; including number and location of insurance policies, and claims.
- External influencers, such as catastrophe events or legislative changes.
- Caseload per investigator
- Budgetary constraints

Integrated in the Business Processes

When developing and building a special investigations unit, one of the first things done is defining the SIU's role and area of responsibility within the company. Usually determined by corporate leadership, some anti-fraud units are part of the organization, while others are contracted externally via third-party. They can be a separate division reporting to anti-fraud unit leadership or serve as an extension of the claims department. There appears to be no perfect or singular solution regarding the assignment or attachment within the organization. The anti-fraud unit is responsible mitigating the risk of potential loss to the company by identifying and deterring insurance fraud. The integration of the anti-fraud unit into the organization is critical to the success and failure, so care must be given in deciding and defining their role.

Cost of Creating an Anti-fraud Unit

Management should consider these factors when budgeting or funding a successful SIU:

- Personnel Cost - Salary & Benefits
- Relocation fees
- Employee selection cost - advertisement
- Recruitment cost - Background, drug test
- Training - New employee orientation
- Equipment - computer
- Office Space - Furniture, phone, etc.
- Transportation Cost - Purchase, lease, rental, or mileage reimbursement
- Investigative software - programs, licenses, and renewals
- State licenses - all lines, private detective, etc.
- Professional classifications

Personnel Selection

Hiring the right person to work in a demanding and challenging anti-fraud environment is critical to the program's success. Anti-fraud managers should require some basic qualifications:

1. The selected member should possess a degree from an accredited college or university.
2. The selected member should possess a minimum of 3 years special investigation insurance claims experience and/or investigative law enforcement experience, military, adjuster, or private detective.
3. The selected member should possess a solid understanding of SIU or relevant claim processes, practices, and applicable laws and regulations strongly preferred
4. The selected member should possess professional certification designation in CFE, CIFI, FCLS, or FCLA are strongly preferred.

5. The selected member should possess strong interviewing and communication skills (verbal and written)
6. The selected member should possess the ability to work well independently and in a team environment.
7. The selected member should have a verifiable history of a consistently high level of performance and achievement.
8. The selected member should possess strong critical thinking and analytical skills; ability to make deductions; logical and sequential thinker
9. The selected member should possess excellent written and verbal communication and diplomacy skills, inspiring confidence among main customers
10. The selected member should have the ability to work well independently and in a team environment

SIU Team Member Essential Functions and Responsibilities

1. Performs research investigation assignments as requested by examiners, clients, or legal counsel.
2. Conducts thorough search and inspection of general public and subscription database records.
3. Conducts comprehensive background investigations, medical and other facility canvasses, social media searches, social media monitoring, geo-fencing, and other specialized research investigations.
4. Documents findings in a detailed, professional investigative report.
5. Identifies, documents, and communicates red flag indicators and makes additional handling recommendations as appropriate.
6. Maintains proper documentation of all relevant facts and evidence pertaining to the case in the appropriate claim handling system(s) and ensures investigations are completed according to service expectations and SIU best practices.
7. Proper time management and ability to prioritize the task.
8. Maintains technical competency and adherence to all applicable legal codes and statutes to ensure all investigations are conducted in a legal and ethical manner.
9. Complies with deposition and courtroom testimony appearances as requested.
10. Conducts training for new team members as requested.

Anti-Fraud Plans

The concept of mandating the submission of an insurer's anti-fraud plan was developed to encourage insurers with direct written premiums to fight insurance fraud proactively by drafting a plan to fight fraud. This plan, along with audits, inspections, or in conjunction with a market conduct examination, ensures the Insurer is following its submitted anti-fraud plan.

Florida State Statute 626.9891(1)(d) states by December 31, 2017, every insurer admitted to do business in this state shall: electronically file with the Division of Investigative & Forensic Services of the department, and annually thereafter, a detailed description of the anti-fraud unit or division or a copy of the contract executed under subparagraph(a)(2), as applicable, a copy of the anti-fraud plan, and name of the employee designated under paragraph (c).

An insurer must include the additional cost incurred in creating a distinct unit or division, hiring additional employees, or contracting with another entity to fulfill the requirements of this section, as an administrative expense for ratemaking purposes.

(3) Each anti-fraud plan must include the following:

- (a) An acknowledgment that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance by that insurer;
- (b) An acknowledgment that the insurer has established procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Investigative and Forensic Services of the department;
- (c) An acknowledgment that the insurer provides the anti-fraud education and training required by this section to the anti-fraud investigative unit;
- (d) A description of the required anti-fraud education and training;
- (e) A description or chart of the insurer's anti-fraud investigative unit, including the position titles and descriptions of staffing; and
- (f) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors.

Viatical Provider Anti-Fraud Plan

626.99278 - Every licensed viatical settlement provider and registered life expectancy provider must adopt an anti-fraud plan and file it with the Division of Investigative and Forensic Services of the department. Each anti-fraud plan shall include:

- (1) A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications.
- (2) A description of the procedures for the mandatory reporting of possible fraudulent insurance acts and prohibited practices set forth in s. 626.99275 to the Division of Investigative and Forensic Services of the department.

- (3) A description of the plan for anti-fraud education and training of its underwriters or other personnel.
- (4) A written description or chart outlining the organizational arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and for the investigation of unresolved material inconsistencies between medical records and insurance applications.
- (5) For viatical settlement providers, a description of the procedures used to perform an initial and continuing review of the accuracy of life expectancies used in connection with a viatical settlement contract or viatical settlement investment.

Entities listed below are exempt from anti-fraud plan filings:

- Self-insured funds
- Self-insured employers
- Surplus Lines non-admitted companies
- Reinsurance companies
- Prepaid legal service organizations
- Prepaid medical/dental
- Premium Finance companies
- Fraternal organizations
- Service Warranty companies
- Continuing Care facilities
- Non-Profit Organizations

69D-2.005 Compliance and Enforcement.

- (1) The Division shall review the filings of SIU and insurer anti-fraud plans and the Office may conduct audits pursuant to Section 624.3161, F.S., to determine compliance with Section 626.9891, F.S., and this rule chapter.
- (2) If an insurer fails to timely file an anti-fraud plan or fails to implement or follow the provisions of their anti-fraud plan, fails to report the required data related to fraud for each identified line of business written by the insurer, or in any other way fails to comply with the requirement of section 626.9891, F.S., and this rule chapter, the Department, Office, or Commission may take appropriate administrative action in accordance with Section 626.9891(8), F.S., and Section 624.4211, F.S., and rule 69O-142.011, F.A.C.

Methods for Detecting and Investigating Insurance Fraud

The identification of suspected insurance fraud remains a major part of the claim professional's job. Underwriting representatives evaluate the risk for policyholders seeking coverage. Adjusters and examiners investigate insurance claims, negotiate settlements, and authorize payments. They determine whether the customer's insurance policy covers the loss and how much of the loss should be paid to the insured and/or claimant. When fraud is suspected, the matter is referred to the SIU whose primary purpose is the investigation and disposition of suspect claims and policies. Referrals to the SIU are based upon industry-accepted fraud indicators, commonly referred to as "red flags." The presence of one or more fraud indicators is not evidence of fraud; it only means that the claim or policy should be referred to the SIU for further investigation.

Data analytics technology is playing an increasingly important role in the insurance business. In the most recent fraud technology survey, 100 percent of insurers indicated they employed technology for detecting claims fraud and 55 percent used technology to uncover underwriting fraud. (Coalition Against Insurance Fraud – 2019)

Working alongside underwriters and adjusters, analytics can collect and analyze structured and unstructured data and flag policies and claims for closer inspection. For this reason, insurers may leverage analytic solutions, such as predictive modeling, link-analysis, and rules-based algorithms. These solutions, typically based upon identifying indicators within data, increase the speed of detection and help expose known and unknown crime rings.

An insurer may provide a direct line of communication in constant operational readiness to facilitate immediate intake for consumer complaints of fraud and abuse. These usually involve implementing toll-free telephone service available to the public; or an internet email/contact page.

Investigation and the Basic Principles of Evidence

The purpose of the SIU investigation is to examine and determine the veracity of an insurance application, claim filing, and/or allegations of fraudulent practices. This inquiry typically involves obtaining admissible evidence, including witness statements, documents, "real" evidence, (such as construction materials from a home); and demonstrative evidence, (such as photos, charts, and graphs).

Recording Statements: Florida Security of Communications Act, Chapter 934 of the Florida Statutes, recognizes that oral, electronic, and wire communications are private, unless both parties consent, and cannot be recorded, absent a specific statutory exception. The legislative intent behind this statute is to safeguard the privacy of innocent people to prevent unauthorized interception of these communications. Fl.St. § 934.01(4).

Documentary evidence is generally used to prove a fact that is contained in the information it offers. Written documents, photographs, videos, sound recordings, and printed e-mails or web pages are all examples of documentary evidence. This evidence is typically presented at trial as an exhibit provided there is a legal foundation that explains what it is, where it came from, and that it follows the best evidence rule (refer to Section 90.952 of the Florida Statutes.)

Preserving Evidence: In Florida, the duty to preserve evidence relevant to a case may arise long before a complaint is filed. A party's duty to preserve evidence is triggered once litigation is reasonably anticipated. The duty extends to any evidence that a party knows, or reasonably should know. The failure to preserve relevant evidence, also known as the spoliation of evidence, may result in the imposition of sanctions and a rebuttable presumption shifting the burden of proof in the underlying action.

Procedure to Identify, Prevent and Detect Insurance Fraud

One of the most important issues facing insurance carriers and investigators is the development and implementation of a fraud control policy developed to serve as a consistent guide toward effective fraud prevention, identification, and detection. Staff and investigations can only be expected to comply with a procedure if it is clearly set out in a document that details procedures to be followed. Where no such document exists, it is often difficult to prove that external parties have followed specific procedures. Indeed, the lack of clear guidelines is often the first excuse suspected offenders will use when questioned concerning fraudulent acts.

When addressing internal organizational procedures, it is less cumbersome when determining if employees are following protocol. However, companies should consider the following when developing or modifying existing procedures:

- Number of policies in effect
- Number of claims received
- Number of suspected fraudulent claims detected
- Need for staff to efficiently authenticate claims received
- Need for fraud detecting software or utilize “red flag” indicators
- Need for two (2) tier reviews for fraud referrals to ensure substance and validity
- Anti-fraud unit staffed at the level needed
- Anti-fraud unit oversight.
- Guidelines for exchange of information between administration, legal and anti-fraud units.
- Guidelines for anti-fraud units to report claim information and accurately document for future usage.

To be successful, it is recommended anti-fraud personnel has a general understanding of:

- All insurance policy contracts within the company
- Rules applied by the court for interpretation of insurance contracts
- Insurer’s policy applications, method of submission, and types of misrepresentation
- Florida state statute 626.989 and other statutes associated with insurance fraud
- Florida Office of Insurance Regulation standards
- Insurance fraud investigative techniques
- Interview techniques
- Internal early warning systems
- The emergence of new fraud schemes, the detection, and components
- Insurance fraud criminal statutes and the elements necessary for prosecution

Leverage Analytics to Fight Fraud

With the growing complexity of fraud, insurers need to put in place forward-looking fraud detection techniques that efficiently analyze data and help minimize fraud loss. Insurers tend to collect large amounts of structured, semi-structured, and unstructured data, which are seldom evaluated in fraud investigation operations. Combining analysis of data along with the existing fraud detection techniques enables insurers to enhance the productivity of underwriting and claims processes and maintain a competitive advantage. As insurers move to analytics to detect fraud, specific policies should be considered regarding how data is compiled. The use of technological tools with sophisticated computer analytics can make certain programs are evaluated for accuracy and fairness.

Analytics can assist with compiling red flag indicators which include, but are not limited to:

- Excessive prior claims history
- Financial distress
- Policy inception
- Coverage inquiry
- Insured is overly pushy for a quick settlement
- Losses include total contents of business/home, including items of little or no value
- Handwritten receipts
- Property/Vehicle is not available for inspection
- The vehicle has an unusual amount of aftermarket equipment

Investigating Suspected Insurance Fraud

The anti-fraud unit should establish, maintain, distribute, and adhere to written guidelines for the investigation of suspected insurance fraud. An investigation of suspected insurance fraud should include:

- (1) A thorough examination of a claim file, application, or insurance transaction, that includes consideration of factors indicating insurance fraud.
- (2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.
- (3) Utilizing one or more industry-recognized databases identified by the SIU as appropriate for use in fraud investigations involving the particular line of insurance in question.
- (4) Preservation of documents and other evidence obtained during an investigation
- (5) Writing a concise and complete summary of the entire investigation, which is specific to the investigation at hand, is separate from any other document prepared in connection with the investigation, and includes the investigators' findings regarding the suspected insurance fraud and the basis for their findings. The summary should answer the following questions:
 - (A) What facts caused the reporting party to believe insurance fraud occurred or may have occurred?
 - (B) What are the suspected misrepresentations and who allegedly made them?

- (C) How are the alleged misrepresentations material and how do they affect the claim or insurance transaction?
- (D) Who are the pertinent witnesses to the alleged misrepresentation if there are pertinent witnesses?
- (E) What documentation is there of the alleged misrepresentation, if documented?
- (F) In addition, the summary prepared pursuant to this subdivision (a)(5) should include a statement as to whether the investigation is complete.

Each investigation of suspected insurance fraud should include performing at least the procedures specified pursuant to the extent they are applicable.

The anti-fraud unit should investigate each credible referral of suspected insurance fraud that it receives. A credible referral of suspected insurance fraud is one that includes a red flag or fraud indicators. However, upon a preliminary review, the anti-fraud unit determines that it is reasonably clear that the red flag or fraud indicators contained in the referral are not the result of suspected insurance fraud, the anti-fraud need not forward a referral to DIFS.

Brief Summary of Crime

- ▶ Claim number
- ▶ Target/suspects
- ▶ Date & Location
- ▶ Amount of Loss
- ▶ Materiality Statement

Evidence Available

- ▶ Recorded Statements
- ▶ False Statements
- ▶ Documents - Bank, phone
- ▶ Video
- ▶ License Plate Readers

Technology & Emerging Trends

The use of technology in anti-fraud efforts is critical. Fraudulent claims which go undetected have a negative net effect on the insurance industry each year. With the use of technology, insurers can stay ahead of emerging trends and prevent all efforts of attack from outside sources intending to make a profit from illegitimate claims. There is a wide variety of technology being used by industry professionals and professional organizations around the United States. The most commonly and widely used technology in anti-fraud units are as follows:

- Automated red flags technology
- Leverage predictive modeling technology/proactive fraud analytic models
- Social media technology
- Anomaly detection technology
- Data/Text mining technology

- Link Analysis technology
- Data mapping technology
- Image Forensic technology/ Digital fraud
- Automated case management technology

Emerging Trends

- Cyber fraud
- Money laundering
- Criminal fraud rings
- Identity theft
- Attorney litigation fraud
- COVID-19 Claims

Anti-Fraud Education & Training

It is expected those involved in the handling of claims and policies are properly trained to facilitate the detection, investigation, and reporting of insurance fraud. This generally involves claims and underwriting representatives and may extend to call centers, legal, and others within the insurance enterprise.

Legislative actions require insurers to provide a minimum (2) hours of training to employees within the anti-fraud unit on topics that include the detection, investigation, evaluation, and reporting of insurance fraud.

Insurers may choose to create and provide internal or external training to meet their continuing educational needs. Approximately 56 percent of respondents to the 2020 Anti-Fraud Benchmarking Study indicated that their SIU representatives receive more than 15 training hours during the calendar year. (Coalition Against Insurance Fraud, 2020)

An anti-fraud employee should have training annually on topics closely related to the continued educational development of the employee. The anti-fraud training should consist of the following:

- (A) investigative techniques
- (B) DIFS and authorized governmental agencies
- (C) fraud indicators
- (D) emerging fraud trends; or
- (E) legal and related issues

The State of California requires each insurer to establish and maintain an ongoing anti-fraud training program, planned and conducted to develop and improve the anti-fraud awareness skills of the integral anti-fraud personnel.

The statutory language says an insurer shall designate an anti-fraud staff person to be responsible for coordinating the ongoing anti-fraud training program.

The anti-fraud training program shall consist of the following:

All newly hired employees shall receive an anti-fraud orientation within ninety (90) days of commencing assigned duties. The orientation shall provide information regarding:

- (A) the function and purpose of the anti-fraud unit
- (B) an overview of fraud detection and referral of suspected insurance fraud to the SIU for investigation
- (C) a review of the DIFS insurance fraud reporting requirements
- (D) an organization chart depicting the Insurer's SIU; and
- (E) SIU contact telephone numbers and email addresses.

Designated anti-fraud personnel shall receive annual anti-fraud in-service training, which shall include:

- (A) review of the function and purpose of the SIU
- (B) introduction/review of the written procedures established by the SIU regarding the identification, documentation, and referral of incidents of suspected fraud to the SIU
- (C) identification and recognition of red flags or red flag events
- (D) any changes to current procedures for identifying, documenting, and referring incidents of suspected insurance fraud to the SIU
- (E) the DIFS insurance fraud reporting requirements; and
- (F) introduction/review of existing and new, emerging insurance fraud trends.

The training requirements are not required to persons retained to provide an expert opinion on a medical, technical, or scientific topic on behalf of the Insurer and who do not participate in the claims handling or decision-making function of the Insurer.

Training, instruction, or courses that may be used in order to satisfy the requirement stated in this section shall include, without limitation: anti-fraud conferences; SIU roundtables hosted by DIFS; task force meetings; anti-fraud association meetings and training; and insurer in-house training sessions.

Continual education can be attained through a variety of methods, including:

- Live and pre-recorded webinars.
- National and local insurance industry seminars offered through various organizations.

- Certifications and designations that may be pursued through governing organizations, such as American Educational Institute: Fraud Claims Law Associate (FCLA), and Fraud Claims Law Specialist (FCLS)
- International Association of Special Investigation Units (IASIU): Certified Insurance Fraud Investigator (CIFI), and Association of Certified Fraud Examiners (ACFE); Certified Fraud Examiner (CFE).

Records of the anti-fraud training shall be prepared at the time training is provided and be maintained and available for inspection by the DIFS on request. The training records shall include:

- (1) the title and date of the anti-fraud training, instruction, or course
- (2) the name, title, and contact information of the instructor(s), to the extent applicable
- (3) copies of the training, instruction, or course materials or, if the materials are unavailable, a description of the training, instruction, or course content
- (4) the length of the training, instruction, or course; and
- (5) the name and job title(s) of participating personnel.

Carrier to Carrier Sharing

The provisions within 626.989 provide qualified immunity against civil actions (libel, slander) when sharing internal information, such as claim file documents, between carriers concerning suspected acts of insurance fraud, provided that:

- Those sharing information are on file with Florida's fraud as designated employees whose duties include the investigation and disposition of claims relating to suspected fraudulent acts; and
- The information is only used for confirming/refuting a suspected fraudulent insurance act. (The information cannot be simply for establishing damages)

626.989 requests are generally made in writing after verbal contact with the SIU designee to confirm they have records that are material to the investigation; the letter should contain their insured's name, claim number, date of loss, and name of the SIU investigator assigned the investigation.

Reporting Insurance Fraud to DIFS

Wherein, during the investigation of an insurance matter, it is determined that the elements of fraud are believed to exist, it is essential to report the matter to the DIFS as mandated by Florida Statute. While there are no mandated timeliness governing when a suspected insurance matter is reported to the DIFS, it generally should occur at the conclusion of the investigation. In some cases, it may be prudent for the insurer to report suspected claim fraud to the DIFS after the disposition of the claim.

Insurers or other entities or persons subject to mandatory reporting requirements of subsection 626.989(6), F.S., shall report suspected fraudulent acts electronically on Form [DFS-L1-1691](#), <http://www.flrules.org/Gateway/reference.asp?No=Ref-09344>, Suspected Fraud Referral Form (Rev.

03/18), on the Division's website at www.myfloridacfo.com or via an electronic reporting interface that is linked to the Division (e.g. the National Insurance Crime Bureau or ISO sites). Form [DFS-L1-1691](#) is hereby incorporated by reference. Insurers shall electronically provide the following with regard to reporting suspected fraudulent activity:

1. An acknowledgment that all reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.
2. An acknowledgment that the insurer or anti-fraud investigative unit shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the Division.

(b) Insurers shall include the acknowledgements set forth in subparagraphs (2)(a)1. and 2., electronically on Form [DFS-L1-1689](#), the Anti-Fraud Plan.

(3) The filing of the information required herein is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its anti-fraud investigative unit, its anti-fraud investigative unit description, or its anti-fraud investigative unit policies and procedures.

Rulemaking Authority 624.308, 626.9891 FS. Law Implemented 624.307, 626.989, 626.9891 FS. History—New 10-5-06, Amended 5-8-18.

626.989(6) - Mandatory Reporting Requirement

Any person, other than an insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. [817.234](#), is being or has been committed may send to the Division of Investigative and Forensic Services a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may request. Any professional practitioner licensed or regulated by the Department of Business and Professional Regulation, except as otherwise provided by law, any medical review committee as defined in s. [766.101](#), any private medical review committee, and any insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. [817.234](#), is being or has been committed shall send to the Division of Investigative and Forensic Services a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may require.

Section [627.736\(4\)\(i\)](#), Florida Statutes, provides that “[a]ll claims denied for suspected fraudulent insurance acts shall be reported to the Division of Investigative and Forensic Services.

Section [626.9891](#), Florida Statutes, authorizes the Department of Financial Services, Division of Investigative and Forensic Services (DIFS) to adopt rules relating to Insurer Special Investigative Units (SIUs) and Anti-Fraud Plans. These rules are set forth in Ch. 69D-2, F.A.C.

Sources of Referrals and Tips

There are several ways to report insurance fraud to the DIFS. The Division maintains an insurance fraud reporting portal via the DIFS website: first.fldfs.com used explicitly to receive fraud complaints from insurance companies, attorneys, citizens, law enforcement, and other governmental entities. There are also other means to report fraud to DIFS. Additionally, fraud reporting is received from member companies through the National Insurance Crime Bureau portal (NICB), National Association of Insurance Commissioners (NAIC), telephone, email, mail, walk-ins, and others. The best practice for submitting a referral to DIFS is through the Division's portal. Although the preferred method of anti-fraud personnel is through the NICB portal, DIFS recommends using the Division's portal.

The Division of Investigative and Forensic Services receives over seventeen thousand referrals annually. The Division investigates all insurance-related crimes but is not limited to the following:

- a. Auto Fraud
- b. Application Fraud
- c. Insurance Claim Fraud
- d. Healthcare Fraud
- e. Life Insurance Fraud
- f. Licensee Fraud - Insurance Agent, Bail Bonds, Closing Agent, Adjusters, Etc.
- g. Unauthorized Entity Fraud
- h. Insolvency Fraud
- i. Workers' Compensation Claim Fraud
- j. Workers' Compensation Premium Avoidance Fraud
- k. Disability Fraud
- l. Homeowners Fraud
- m. Identity Theft Fraud
- n. Marine Fraud
- o. Warranty Fraud
- p. Commercial Fraud

A regional captain or designee receives and examines each referral received by the Division. If the referral is opened into a case, the referral is assigned to a sworn detective for follow-up. The Division opens over ten percent of good referrals received annually into criminal investigations. The remaining referrals are closed due to insufficient evidence, lack of response from the reporting party, below the investigative threshold, and other selective closing methods.

Referrals opened into criminal cases are based on a triage system that utilizes case solvability factors in the Suspected Fraud Report Form. A properly submitted suspected fraud form should indicate the existence of evidence of the following:

- a. Known suspect
- b. Witness(s)
- c. Direct Evidence
- d. Investigative Reports
- e. Audio Tapes
- f. Conflicting Statements
- g. Falsified Documents
- h. Photographs
- i. Multiple Claims for Same Loss
- j. Medical Reports Correspondence
- k. Depositions/EUO Sworn Statements
- l. Claimant lied under oath
- m. Was there an opportunity for anyone other than the suspect to commit the crime?
- n. Recognizable Method of Operation

Referrals made to the DIFS fraud reporting portal must be clear, concise, accurate, detailed, and timely. Timeliness is critical to the success and development of referrals sent to the Division. For example, the State of California Insurance Fraud Code 1872.4(a) states, any company licensed to write insurance in the state that reasonably believes or knows that a fraudulent claim is being made shall, within 60 days after the determination by the Insurer that the claim appears to be a fraudulent claim, send to the Fraud Division. Evidence needed is sometimes lost due to lack of timeliness, such as telecommunication companies or video from businesses and government facilities are lost due to inconsistent retention schedules. The absence of critical information or evidence could result in the referral being closed.

Red Flags - Defined as patterns or trends that may indicate fraud, waste, abuse, factors, or circumstances present on a claim, and behavior history of the person (s) submitting the claim or application. Red flag indicators should cover each line of business allowed in Florida. The use of red flags should serve only as an indicator, and not the sole reason for reporting. Below are some commonly identified red flag indicators:

- Excessive prior claims history
- Financial distress
- Claim filed early since policy inception
- Coverage inquiry
- Insured is overly pushy for a quick settlement
- Losses include total contents of business/home including items of little or no value
- Handwritten receipts
- Property/Vehicle is not available for inspection
- The vehicle has an unusual amount of aftermarket equipment

The sample language used below in referrals are considered inadequate and highly discouraged and usually results in referral closure due to insufficient evidence without additional information are:

1. Services not rendered
2. Insured failed to appear for EUO
3. Multiple claims in the same policy period
4. Claim occurred 60 days within police inception
5. Claimant not listed in the police report
6. The provider being reviewed for excessive billing
7. Provider listed in NICB Alert
8. Past arrest by DIFS or other law enforcement agency
9. Insured has prior claims and arrest

Compliance with Investigative Demand Letters

Florida State Statute 626.989 authorizes law enforcement personnel to request claim files, records, notes, or any information material to the alleged fraud. All material requested, as a practice, should be provided to the requesting law enforcement officer within 30 days of the request. A single demand letter is sufficient throughout the investigation.

Adequate Staffing Levels and Knowledge within Anti-fraud Units

Anti-fraud unit staffing levels should be determined by its demonstrated ability to establish, operate, and maintain an SIU that follows administrative rules, statutes, and internal regulations. Factors that may be considered in staffing the SIU include, but are not limited to, the number of policies written and individuals insured in Florida, the number of claims received with respect to Florida insureds on an annual basis, the volume of suspected fraudulent Florida claims currently being detected and other factors relating to the vulnerability of the Insurer to insurance fraud.

A successful anti-fraud unit should be composed of employees who have the knowledge and/or experience in general claims practices, the analysis of claims for patterns of fraud and current trends in insurance fraud, education and training in specific red flags, red flag events, and other criteria indicating possible fraud. They shall have the ability to conduct effective investigations of suspected insurance fraud and be familiar with insurance and related law and the use of available Insurer related database resources.

An insurer may choose to outsource some or all the SIU functions. According to the most recent SIU benchmarking survey, more than one in five insurers now outsource basic investigative functions to private investigative firms – a trend driven mainly by smaller insurers (*Coalition Against Insurance Fraud, July 2020*)

Measuring Anti-fraud Unit Performance

Measuring the success and failure of an anti-fraud unit is determined by the audit. There are factors that will dictate the anti-fraud unit's success or failure. For example, the number of anti-fraud unit personnel, policies in effect, number of claims filed, number of claims closed, money saved, money lost to settlements by the company.

When deciding how to evaluate current SIU performance or implement performance standards for a newly formed unit, several things must be kept in mind. Some measurement standards will be concrete and easily tabulated. Other factors to be considered will be more unclear and intangible, but both are extremely important in rating the SIU's overall effectiveness.

Below are the factors most used by insurance companies to rate SIU performance:

Number of actual referrals received by the SIU (this involves a combination of direct referrals by claims handlers, fraud hotlines, outside agencies, and other carriers)

- Quality and accuracy of the investigation itself
- Total number of referrals as a percentage of the total number of overall claims
- The total cost of maintaining the SIU versus dollars saved
- Number of files closed without payment

- Number of assists from the SIU
- Number of files that resulted in some type of criminal action
- The total dollar amount of restitution ordered or collected
- The cycle time or “claim life”
- Percentage of claims investigated
- File referral rate by different lines of business
- Number of files that resulted in some type of civil action
- Membership or leadership in anti-fraud organizations
- Average dollar amount paid on SIU claims
- The total dollar amount of recovered premiums
- The SIU’s direct involvement in anti-fraud legislative activity

The measurement tools most often used are the number of actual referrals received by the SIU and the quality and accuracy of the files they investigated. This information is the simplest to track and tabulate, and to a large degree, provides a snapshot of how active the SIU is overall within the organization.

The best practice for determining the success of an anti-fraud unit is the following:

1. The frequency - Establish a consistent measure/evaluation system -quarterly, semi-annually, or annually.
2. Who Measures - Anti-fraud unit, claims senior management, claims executives, legal department, compliance department, and others.
3. Calculated savings - The initial reserve(s) at the time the determination of the suspected fraud or fraud is made. The savings is the difference between what is paid and what was reserved, or the denial amount based on

Mandatory Statistical Data Reporting

Each Insurer licensed in the state is required to report data related to fraud for each identified line of business written during the prior calendar year. The data shall be reported to the DIFS by March 1, 2019, and annually thereafter, and must include, at a minimum:

Each Insurer is required to report data related to fraud for each identified line of business written by the Insurer during the prior calendar year. The data shall be reported to the department by March 1, 2019, and annually thereafter, and must include, at a minimum:

- (a) The number of policies in effect
- (b) The amount of premiums written for policies
- (c) The number of claims received

- (d) The number of claims referred to the anti-fraud investigative unit
 - (e) The number of other insurance fraud matters referred to the anti-fraud investigative unit that was not claim related
 - (f) The number of claims investigated or accepted by the anti-fraud investigative unit
 - (g) The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that was not claim related
 - (h) The number of cases referred to the Division of Investigative and Forensic Services
 - (i) The number of cases referred to other law enforcement agencies
 - (j) The number of cases referred to other entities; and
 - (k) The estimated dollar amount or range of damages on cases referred to the Division of Investigative and Forensic Services or other agencies.
- (6) In addition to providing information required under subsections (2), (4), and (5), each Insurer writing workers' compensation insurance shall also report the following information to the department, on or before March 1, 2019, and annually thereafter:
- (a) The estimated dollar amount of losses attributable to workers' compensation fraud is delineated by the type of fraud, including claimant, employer, provider, agent, or other types.
 - (b) The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other types.
 - (c) The number of cases referred to the Division of Investigative and Forensic Services, delineated by the type of fraud, including claimant, employer, provider, agent, or other types.
- (7) An insurer who obtains a certificate of authority has 6 months in which to comply with subsection (2), and one calendar year thereafter, to comply with subsections (4), (5), and (6)

The Future of the Fight Against Fraud

There is not a more dedicated group of public servants than those who attack insurance fraud at the source, with a mission to reduce costs for all insurance consumers and stop those who take advantage of, often vulnerable, Floridians. As fraud schemes continue to become more sophisticated, fraud fighters must continue to use every available tool to stay ahead, but as with so many initiatives, it takes human ingenuity and increased financial resources to be successful. Insurance fraud investigators are specially trained professionals who can "smell" fraudulent activity and have the drive to stop it. Florida's DIFS is a leader with a force of 127 sworn law enforcement officers whose primary duty is to investigate insurance fraud crimes within the state of Florida. The goal is for DIFS, intelligence, and industry personnel to continue working together to identify new and existing trends related to insurance fraud. Organizations such as the Florida Insurance Fraud Education Committee (FIFEC), the National Association of Insurance

Commissioners (NAIC), and the Coalition Against Insurance Fraud are a few resources used to educate and share information on state and national platforms. Current monthly and quarterly meetings held with resources such as the National Insurance Crime Bureau (NICB) and Florida Property & Casualty Taskforce have proven to be useful to personnel investigating acts of fraud. The strategies developed and ideas shared during these events are critical to the overall success of the investigation of complex cases and organized criminal organizations.

In addition to intelligence sharing, members of these groups understand the benefits of working together on investigative taskforces such as DIFS' Disaster Fraud Action Strike Team (DFAST), Palm Beach County Sober Home Taskforce, and the Greater Palm Beach Health Care Taskforce. These task forces include state and federal officers, insurance industry personnel, and local resources. Due to the effort from the task force members and others, undercover operations are made possible, additional resources are made available, and violators are caught and brought to justice.

Law Enforcement Relationship

A critical component in the success of the anti-fraud unit is forging a working relationship with DIFS and law enforcement. The anti-fraud unit leadership should ask team members to help foster and cultivate interrelationships with all fraud partners by attending anti-fraud meetings, workgroups, and workshops. Anti-fraud unit members should cooperate with law enforcement in all aspects of the investigation to the extent possible within the limits established by statutory guidelines or court-mandated decisions.

Collaboration

Florida continues to be a leader in insurance fraud education and training of insurance professionals. Organizations such as the Florida Insurance Fraud Education Committee (FIFEC). The Florida Advisory Council on Arson Prevention (FACAP). The National Association of Insurance Commissioners (NAIC), and the National Coalition against Insurance Fraud are a few resources used to educate and share information on the state and national platforms. Current monthly and quarterly meetings held with resources such as the National Insurance Crime Bureau (NICB) and Florida Property & Casualty Taskforce have proven helpful to personnel investigating acts of fraud. Forward-thinking developed during these events are critical to the overall success of the investigating of complex cases and organized criminal organizations.



The Florida Insurance Fraud Education Committee (FIFEC)



The Florida Property and Casualty Insurance Fraud Task Force



Coalition Against Insurance Fraud



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

REFERENCES

[Association of Certified Fraud Examiners Insurance Fraud Handbook 2019](#)

[Coalition Against Insurance Fraud:https://insurancefraud.org/fraud-stats/](https://insurancefraud.org/fraud-stats/)

Florida DIFS ACISS Manual

[NAIC Model Laws, Regulations, Guidelines, and Other Resources, Anti-Fraud Plan Guidelines Oct 29, 2020](#)

[SIU Today Spring 2019 How to Build a Major Case Unit](#)

[New Jersey Anti-Fraud Prevention & Detection Procedure Manual 2016](#)

[Law Governing Insurance - State of California](#)

APPENDICES

Appendix A

- Important Links

Appendix B

- Index of Relevant Florida Statutes and Rules

Appendix C

- Statutes and Rules Relating to the Reporting of Suspected Fraud and required reporting of data by insurers

APPENDIX – 1

IMPORTANT LINKS

Division of Investigative and Forensic Services:

<https://www.myfloridacfo.com/division/difs/>

Division of Investigative and Forensic Service SIU Information:

<https://www.myfloridacfo.com/division/difs/special-investigative-unit>

Division of Investigative and Forensic Services Referral Portal:

<https://first.fldfs.com/>

SIU Description/Anti-Fraud Plan Report Filing:

<https://antifraudportal.fldfs.com/Default.aspx>

Division of Investigative and Forensic Services Best Practices:

https://www.myfloridacfo.com/docs-sf/investigative-and-forensic-services-libraries/difs-documents/2018bestpracticesreportv1.pdf?sfvrsn=b07d3ce1_0

Designated Employee Notification- Add/Delete/Status:

DIFSIUAdmin@myfloridacfo.com

REPORTING: Section 626.989(6), F.S. requires insurers to report acts of suspected insurance fraud to the division. **Rule 69D-2** mandates that insurers must report the suspected fraud acts electronically using either the E-file Referral or the NICB interface site:

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0600-0699/0626/Sections/0626.989.html

Florida Administrative Code 69D- Insurer Anti-Fraud Investigative Units and Anti-Fraud Plans:

<https://www.flrules.org/gateway/ChapterHome.asp?Chapter=69D-2>

626.9891 Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance:

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0600-0699/0626/Sections/0626.9891.html

APPENDIX – 2

INDEX OF RELEVANT FLORIDA STATUTES AND RULES

Florida Statutes 817.234

False and Fraudulent Insurance Claims

- Defines insurance fraud elements.
- All claims and application forms must contain a statement. *“Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.”* This paragraph does not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.
- A contractor, or a person acting on behalf of a contractor, may not knowingly or willfully and with intent to injure, defraud, or deceive, pay, waive, or rebate all or part of an insurance deductible applicable to payment to the contractor, or a person acting on behalf of a contractor, for repairs to property covered by a property insurance policy.

Florida Statutes 626.989

Investigation by department of DIFS; compliance; immunity; confidential information; reports to the division

- Defines insurance fraud related to the filing of a false insurance application or claim filing,
- Mandates the creation of fraud units,
- Requires reporting of fraud, and
- Provides qualified immunity for the report of fraud and sharing of information with others as designated by Statute.

FAC
69D-2

Insurer Anti-Fraud Investigative Units

- Mandates insurers must report the suspected fraud acts electronically using either the E-file Referral or the NICB interface site.
- Clarifies what constitutes an allegation of suspected insurance fraud.

Florida
Statute
626.9891

Insurer anti-fraud investigative units; reporting requirements.

- Adoption and electronic filing of an anti-fraud plan.
- Minimum 2 hours Anti-Fraud Training to SIU (1-hour refresher yearly).
- Required Collection and Reporting.

FAC 69B-
220.201

Ethical Requirements for All Adjusters and Public Adjuster Apprentices

- Requires adjusters to subscribe to a code of ethics.
- Outlines ethical treatment of insureds to ensure fair dealings with their insurer.

Florida
Statute
627.711

Notice of Premium discounts for hurricane loss mitigation, uniform verification of inspection forms.

- FS 627.711(6)(a) Prohibits inspectors from offering kickbacks, inducements, rewards, or referral fees to insurance agents, brokers, etc. for the referral of the homeowner to the inspector for insurance-related inspections.
- FS 627.711(6)(b) an insurance agent cannot accept a kickback, inducement, reward, referral fee from an inspector.

APPENDIX – 3

STATUTES AND RULES RELATING TO THE REPORTING OF SUSPECTED FRAUD AND REQUIRED REPORTING OF DATA BY INSURERS

Section 626.9891, Florida Statutes, authorizes the Department of Financial Services, Division of Investigative and Forensic Services (DIFS) to adopt rules relating to Insurer Special Investigative Units (SIUs) and Anti-Fraud Plans. These rules are set forth in Ch. 69D-2, F.A.C.

Rules 69D-2.003(1) and 2.004(1), F.A.C., specifically require each insurer to file, as applicable, with the Division a detailed description of its Anti-Fraud Plan, which filing must also include an acknowledgment that the insurer shall report all suspected fraudulent insurance acts directly to the Division.

To eliminate the reporting of duplicate suspected fraudulent insurance acts, it shall be the policy of the Division, consistent with the procedures established in Ch. 69D-2, F.A.C., that:

(1) An insurer subject to subsection 626.9891(2), F.S., shall file with the Division a completed insurer anti-fraud plan and shall submit the plan electronically via the Division’s website at www.myfloridacfo.com. The completed plan shall be submitted on Form DFS-L1-1689,

<http://www.flrules.org/Gateway/reference.asp?No=Ref-09343>, Anti-Fraud Plan (Rev. 03/18), which is hereby incorporated by reference and available on the Division’s website. The insurer’s filing of the information required on Form DFS-L1-1689 shall constitute an adequately detailed description of its designated anti-fraud unit as required by subsection 626.9891(2), F.S. An insurer that elects to contract with others to investigate and report possible fraudulent insurance acts pursuant to subparagraph 626.9891(2)(a)2., F.S., shall also electronically file a copy of the executed contract with the Division.

(2)(a) Insurers or other entities or persons subject to mandatory reporting requirements of subsection 626.989(6), F.S., shall report suspected fraudulent acts electronically on Form DFS-L1-1691, <http://www.flrules.org/Gateway/reference.asp?No=Ref-09344>, Suspected Fraud Referral Form (Rev. 03/18), on the Division’s website at www.myfloridacfo.com or via an electronic reporting interface that is linked to the Division (e.g. the National Insurance Crime Bureau or ISO sites).

Insurers shall electronically provide the following regarding reporting suspected fraudulent activity:

- 1. An acknowledgment that all reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.*
- 2. An acknowledgment that the insurer or anti-fraud investigative unit shall record the date that suspected fraudulent activity is detected and shall record the date that reports of such suspected insurance fraud are sent directly to the Division.*

(b) Insurers shall include the acknowledgments set forth in subparagraphs (2)(a)1. and 2., electronically on Form DFS-L1-1689, the Anti-Fraud Plan.

(3) The filing of the information required herein is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality, or any proprietary interest in its anti-fraud investigative unit, its anti-fraud investigative unit description, or its anti-fraud investigative unit policies and procedures.

Further, Section 627.736(4)(i), Florida Statutes, provides that "[a]ll claims denied for suspected fraudulent insurance acts shall be reported to the Division of Investigative and Forensic Services.

Section 626.989(4)(c), Florida Statutes, grants civil immunity, in the absence of fraud or bad faith, for providing the aforementioned required reports of suspected fraudulent insurance acts.

(5) Each insurer is required to report data related to fraud for each identified line of business written by the insurer during the prior calendar year. The data shall be reported to the department by March 1, 2019, and annually thereafter, and must include, at a minimum:

- (a) The number of policies in effect;*
- (b) The amount of premiums written for policies;*
- (c) The number of claims received;*
- (d) The number of claims referred to the anti-fraud investigative unit;*
- (e) The number of other insurance fraud matters referred to the anti-fraud investigative unit that was not claim related;*
- (f) The number of claims investigated or accepted by the anti-fraud investigative unit;*
- (g) The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that was not claim related;*
- (h) The number of cases referred to the Division of Investigative and Forensic Services;*
- (i) The number of cases referred to other law enforcement agencies;*

- (j) *The number of cases referred to other entities; and*
 - (k) *The estimated dollar amount or range of damages on cases referred to the Division of Investigative and Forensic Services or other agencies.*
- (6) *In addition to providing information required under subsections (2), (4), and (5), each insurer writing workers' compensation insurance shall also report the following information to the department, on or before March 1, 2019, and annually thereafter:*
- (a) *The estimated dollar amount of losses attributable to workers' compensation fraud is delineated by the type of fraud, including claimant, employer, provider, agent, or other types.*
 - (b) *The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other types.*
 - (c) *The number of cases referred to the Division of Investigative and Forensic Services, delineated by the type of fraud, including claimant, employer, provider, agent, or other types.*

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF INVESTIGATIVE AND FORENSIC SERVICES**

200 East Gaines Street
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